STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/13/15 Facility Number: 000369 Provider Number: 155530 AIM Number: 100275190 At this Life Safety Code survey, South Shore Health & Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms.	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The facility has a capacity of 129 with a census of 63 at the time of the survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the wooden shed in the back used for maintenance storage. Quality Review completed on 10/19/15 - DA			
K 0021 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 2 of 2 Kitchen doors, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice could affect staff and 35 residents using the Large Dining Room. Findings include:	K 0021	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective**	11/12/2015

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	Based on observation with the Maintenance Manager on 10/13/15 at 12:47 p.m., one of the Kitchen doors was propped open with a door stop. Another Kitchen door was open because the bottom of the door was catching on the floor. Based on interview at the time of each observation, the Maintenance Manager acknowledged the aforementioned conditions. 3.1-19(b)		**actionsaccomplished for those residents found to be affected by the alleged deficientpractice:** The doorstop was removed from 1of 2 kitchen door and 2 of 2 kitchen door was repairedso as not to catch on the floor and to properly close. **Identification of otherresidents having the potential to be affected by the same alleged deficientpractice and corrective actions taken** All other hazardous area doors in the facilityhave been checked to ensure proper functioning and that no other door props arepresent. No new issues noted. **Measures put in placeand systemic changes made to ensure the alleged deficient practice does notrecur.** Kitchen staff have been in-serviced about theimportance of having doors shut and not propped open. Maintenance manager ordesignee will check all doors in the facility to ensure proper functioning andthat there are no door props present. **How will the corrective actionbe monitored to ensure the deficient practice will not recur?** TheMaintenance Manager will conduct rounds weekly to ensure that the all facilitydoors including the kitchen doors are properly closing and not propped	

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			open.Results of weekly audits will be reported at monthly QAPI meeting, or untilproblem is considered resolved. Problem will be considered resolved whenno new issues are identified over a two month period.	
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be	K 0025	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective actionsaccomplished for those residents found to be affected by the alleged deficientpractice**. All identified penetrations noted will be sealed with 3M Fire Barrier 4Hr rated caulk by 11/12/15. 2. **Identification ofother**	11/12/2015

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	protected by an approved device designed for the specific purpose. This deficient practice could affect staff and up to 36 residents. Findings include: Based on observations with the Maintenance Manager on 10/13/15 at 1:58 p.m. then again at 2:07 p.m., the smoke barrier near resident room 414 above the ceiling tile was an unsealed penetration which was a 1 inch by 4 inch around conduit. Additionally, insulation was stuffed into the smoke barrier. Then again the smoke barrier near resident room 316 above the ceiling tile was an unsealed penetration which was a half of an inch around cable wires. Additionally, insulation was stuffed into the smoke barrier. Based on interview at the time of each observation, the Maintenance Manager acknowledged each aforementioned condition. 3.1-19(b)		**residents having the potential to be affected by the same allegeddeficient practice and corrective actions taken.** All remaining smokebarriers were inspected for un-sealed penetrations. No findings. 3. **Measures put inplace and systemic changes made to ensure the alleged deficient practice doesnot recur.** Any new construction or repairs involving wires or pipes penetratingfirewalls will be sealed with 3M Fire Barrier 4Hr rated caulk. 4. **How will thecorrective action be monitored to ensure the deficient practice will not recur?** Any new construction orrepairs involving wires or pipes penetrating firewalls will be inspected by theMaintenance Manager, or designee, for appropriate fire barrier applicationprior to completion of project.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are			

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	separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Kitchen Storage room, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice could affect staff and 35 residents using the Large Dining Room. Findings include: Based on observation with the Maintenance Manager on 10/13/15 at 12:31 p.m., the Kitchen storage room opens to the corridor which is open to the Large Dining room. Inside the Kitchen storage room was at least sixty boxes stored on top of one another. The Kitchen storage room did not positively latch into the frame when tested. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned condition. 3.1-19(b)	K 0029	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective actionsaccomplished for those residents found to be affected by the alleged deficientpractice.** Aself-closing mechanism was installed on the indicated Kitchen storage door. Thiswas tested to assure door latches properly. This was completed on 10/16/15. **Identification of otherresidents having the potential to be affected by the same alleged deficientpractice and corrective actions taken.** All other hazardous area doors have beenchecked to ensure that they have properly close and positively latch. Noother issues identified. **Measures put in placeand systemic changes made to ensure the alleged deficient practice does notrecur.** Maintenancemanager or designee will audit doors weekly to ensure proper	11/12/2015

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			functioning. **Howwill the corrective action be monitored to ensure the deficient practice willnot recur?** Results of weekly audits will be reported atQAPI monthly meetings or until problem is considered resolved. Problemwill be considered resolved when no new issues are identified over a two monthperiod.	
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 Large Dining Room exterior exit discharge paths were readily accessible at all times. This deficient practice could affect visitors, staff and at least 35 residents in the Large Dining Room. Findings include: Based on observation with the Maintenance Manager on 10/13/15 at 11:59 a.m., the Large Dining Room exit discharged into a gated area. The gate door had a locked padlock. Based on interview at the time of observation, the Maintenance Manager said only maintenance has a key to the padlock and acknowledged the aforementioned condition.	K 0038	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective actionsaccomplished for those residents found to be affected by the alleged deficientpractice.** Keys to the identified Dining Room exit gatedoor have been distributed to all activity staff and nurse supervisors on eachshift. This will ensure that if there was an emergency on any shift a staffmember could open the gate. **Identification of otherresidents having the potential to be**	11/12/2015

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	3.1-19(b)		**affected by the same alleged deficientpractice and corrective actions taken.** No others identified. **Measures put in place andsystemic changes made to ensure the alleged deficient practice does not recur** MaintenanceManager in-serviced the activities staffas well as the nurse supervisors on each shift on how to make sure gate key ison key ring and how to open lock. Maintenance Manager or designee will auditstaff who were assigned gate keys to ensure that they have them on theirperson. **How will the corrective actionbe monitored to ensure the deficient practice will not recur?** MaintenanceManager will be report findings at the monthlyQAPI meeting. This will be on-going.	
K 0044 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and	K 0044	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective**	11/12/2015

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	Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and only the 35 residents that might be in the Large Dining Room, because the 200 Hall is being renovated. Findings include: Based on observation with the Maintenance Manager on 10/13/15 at 12:08 p.m. the fire doors near the Large Dining Room failed to latch when tested. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned condition. 3.1-19(b)		**actionsaccomplished for those residents found to be affected by the alleged deficientpractice.** The fire doors identified during the surveyhave been repaired and are closing properly. **Identification of otherresidents having the potential to be affected by the same alleged deficientpractice and corrective actions taken.** All other fire doors have been checked forproper closing. All found to be working properly. **Measures put in place andsystemic changes made to ensure the alleged deficient practice does not recur.** Maintenance Manager or designee will ensureproper functioning of smoke doors during monthly fire drills which would occurat least twice a month. **How will the corrective actionbe monitored to ensure the deficient practice will not recur?**The results of fire drills will be reported to the monthly QAPImeeting. This will be on-going.	
K 0045 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the	K 0045	This Plan of Correction constitutes my written allegation	11/12/2015

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	facility failed to provide exterior emergency lighting for 1 of 1 external Large Dining Room exit. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect staff and at least 35 in the Large Dining Room. Findings include: Based on observation with the Maintenance Manager the Large Dining Room exit discharge had a battery operated emergency light that was not lit at the time of observation. Based on interview at the time of observation, the Maintenance Manager explained the light is not working and needs to be replaced. 3.1-19(b)		of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective actionsaccomplished for those residents found to be affected by the alleged deficientpractice.** The identified battery operated emergencylight was replaced on 10/14/15 and is in proper working order. **Identification of otherresidents having the potential to be affected by the same alleged deficientpractice and corrective actions taken.** All other batteryoperated emergency lights were surveyed for proper operation. All found to bein proper working order. **Measures put in placeand systemic changes made to ensure the alleged deficient practice does notrecur.** The maintenance manager or designee will conduct and document therequired 30 second monthly and 90 minute annual testing of all battery operatedemergency lights. **How will the correctiveaction be monitored to ensure the deficient practice will not recur?**	

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			Results of auditswill be reported to the monthly QAPI meeting. This will be on-going.	
K 0046 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review and interview; the facility failed to ensure 7 of 7 battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors throughout the facility. Findings include: Based on record review with the Maintenance Manager on 10/13/15 at 10:37 a.m., no documentation was available for review for an annual ninety minute test on seven battery operated	K 0046	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective actionsaccomplished for those residents found to be affected by the alleged deficientpractice.** On10/20/15 the maintenance manager conducted and documented a 30 second monthlyand an annual testing of 90 minutes for the seven identified battery back-uplight fixtures. **Measures put in place andsystemic changes made to ensure the alleged deficient practice does not recur.** Themaintenance manager was in-serviced on 10/20/15 by the administrator regardingthe appropriate testing and documentation requirements of the identifiedbattery back-up emergency lights. **How will the correctiveaction be monitored to ensure the deficient practice**	11/12/2015

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	emergency lights. Based on interview at the time of record review, the Maintenance Manager acknowledged the aforementioned condition. 3.1-19(b)		**will not recur?** The maintenance manager will monitor compliance and report findings atmonthly QAPI meeting. This will be on-going,	
K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 1. Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all staff and residents. Findings include: Based on record review of the "Fire Drill Report" forms with the Maintenance Manager on 10/13/15 at 10:08 a.m., third shift fire drill for the fourth quarter of 2015 was not available for review. Based on interview, the Maintenance Manager acknowledged the aforementioned condition.	K 0050	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective actionsaccomplished for those residents found to be affected by the alleged deficientpractice.** The Maintenance Supervisor is responsible forall fire drills conducted in the facility. The fire drill schedules have	11/12/2015

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	3.1-19(b) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill Report" forms with the Maintenance Manager on 10/13/15 at 10:08 a.m., four sequential second shift fire drills took place between 7:17 p.m. and 8:15 p.m. for four of the last four quarters. Based on interview at the time of record review, the Maintenance Manager acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)		beenreviewed to ensure that all fire drills are conducted at unexpected times. **Identificationof other residents having the potential to be affected by the same allegeddeficient practice and corrective actions taken.** No fire drills will be held within 2 hours ofeach other within the same 12 month period. **Measures put in placeand systemic changes made to ensure the alleged deficient practice does not recur.** The Administrator and Maintenance Manager willreview the yearly fire drill schedule to ensure compliance. **How will the correctiveaction be monitored to ensure the deficient practice will not recur?** The Maintenance Manager will report theschedule at the monthly QAPI meeting	
K 0052 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure 1 of 12 smoke	K 0052	This Plan of Correction constitutes my written allegation of compliance for the deficiencies	11/12/2015

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	detectors was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity		cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective actionsaccomplished for those residents found to be affected by the alleged deficientpractice.** The facility will ensure that documentation isavailable to show testing of the smoke detectors throughout the facility. All smoke detectors have been inspected and are fully functional. Testingof the detectors was completed on 7/14/14. Please see supporting documentationthat indicates that the “Wing 4 small dining” smoke detector that failed wasreplaced. **Identification of otherresidents having the potential to be affected by the same alleged deficientpractice and corrective actions taken.** No other areas affected. **Measures put in placeand systemic changes made to ensure the alleged deficient practice does notrecur.** Administrator in-serviced the Maintenance Manager on the importance offollowing up in a timely manner regarding all testing documentation includingfire alarm, sprinkler, and smoke detector sensitivity.	

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	range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect staff and at least 35 residents. Findings include: Based on record review with the Maintenance Manager on 10/13/15 at 10:18 a.m., the most recent documentation of a smoke detector sensitivity test was completed on 07/24/14 by Reliable Fire and Security indicated that "Wing 4 small dining" smoke detector failed. Based on an interview at the time of record review, the Maintenance Manager acknowledged the aforementioned condition and was unable to provide documentation for repair or replacement. 3.1-19(b)		**How will the correctiveaction be monitored to ensure the deficient practice will not recur?** MaintenanceManager will inform the Administrator of all Fire alarm, sprinkler, and smokesensitivity test schedules and results.	
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are			

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	continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. This deficient practice could affect staff only. Findings include: Based on observations with the Maintenance Manager on 10/13/15 at 11:03 a.m. then again at 1:20 p.m., 22 out of 26 ceiling tiles were missing in Room 405 being used as storage. Then again 14 out of 20 ceiling tiles were missing in the Mechanical Room. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler head in the Kitchen Freezer. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13,	K 0062	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective actionsaccomplished for those residents found to be affected by the alleged.** 1.The ceiling tilesthat were missing in Storage Room 405 have been replaced on 10/16/15. TheCeiling tiles that were missing in the mechanical room have been replaced on10/16/15. 2.The boxes that were 6inches away from the sprinkler head in the freezer have been removed 10/14/15.Also, the ice that was built up on the sprinkler head has been removed10/14/15. 3.The indicated five missingescutcheons will be replaced by 11/10/15. **Identification of otherresidents having the potential to be affected by the same alleged deficientpractice and corrective actions taken deficient practice.** 1.An inventory of thefacility for missing ceiling tiles was	11/12/2015

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	1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice affects staff only. Findings include: Based on observation with the Maintenance Manager on 10/13/15 at 12:36 p.m., the Kitchen Freezer sprinkler head was six inches away from boxes stored near it. Additionally, the sprinkler head had built up ice on the sprinkler head deflector. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned conditions. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure sprinkler heads in the facility were maintained. This deficient practice could affect staff and up to 19 residents. Findings include: Based on observations the Maintenance Manager on 10/13/15 between 1:29 p.m.		conducted with no findings. 2.An inventory of the facility for missing escutcheonswas conducted with no findings. **Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur.** 1.The Administrator in-serviced the maintenancemanager on the need to have all ceiling tiles and sprinkler head escutcheons inplace. Maintenance Manager will audit weekly rounds for missing ceiling tiles. 2.The Maintenance Manager in-serviced the dietarydepartment on the need to have at least an 18” clearance from each sprinklerhead. This action should also stop ice build- up on the sprinkler head. Dietarymanager will audit freezer weekly for compliance. **How will thecorrective action be monitored to ensure the deficient practice will not recur?** Resultsof weekly audits will be reported at QAPI monthly meetings or until problem isconsidered resolved. Problem will be considered resolved when no newissues are identified over a two month period.	

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	and 1:53 p.m., the following sprinkler heads were missing escutcheons: a. 1 of 1 sprinkler head in 500 Hall Nurse's Station Medication Room b. 1 of 3 sprinkler heads at the 500 Hall Nurse's Station Shower Room c. 1 of 2 sprinkler heads in the MDS office d. 1 of 6 sprinkler heads near RR 414 e. 1 of 2 sprinkler heads in the Soiled Utility Room near the 500 Hall Based on interview, The Maintenance Manager acknowledged each missing escutcheon at the time of each observation. 3.1-19(b)			
K 0064 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 6 of 15 fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff and 27 residents.	K 0064	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective**	11/12/2015

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	Findings include: Based on observation on 10/13/15 from 11:32 a.m. to 1:00 p.m., the following was discovered: a) the fire extinguisher near the Time Clock in the 400 Hall last six year test was in 2008. b) the fire extinguisher in the Large Dining Room last six year test was in 2007. c) the fire extinguisher in the Unit 2 East Wing Therapy last six year test was in 2007. d) the fire extinguisher next to Kitchen Storage last six year test was in 2007. e) the fire extinguisher in Kitchen Storage last six year test was in 2008. f) the fire extinguisher near resident room 314 last six year test was in 2007. Based on interview at the time of each observation, the Maintenance Manager acknowledged each aforementioned condition. 3.1-19(b)		**actionsaccomplished for those residents found to be affected by the alleged deficientpractice.** All 6 cited Fire extinguisherswill be replaced by 11/12/15. **Identification of otherresidents having the potential to be affected by the same alleged deficientpractice and corrective actions taken.** The Maintenance Manager completed anaudit of all facility fire extinguishers checking for the required 12 yearhydrostatic test. All in compliance. **Measures put in place andsystemic changes made to ensure the alleged deficient practice does not recur.** Audits for the facility fireextinguishers checking for the required 12 hydrostatic test will be completedmonthly. **How will the correctiveaction be monitored to ensure the deficient practice will not recur?** Results ofmonthly audits will be reported at QAPI monthly meetings or until problem isconsidered resolved. Problem will be considered resolved when no new issuesare identified over a three month period.	
K 0066 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:			

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	(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 2 of 2 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff and at least 25 residents who smoke cigarettes. Findings include: Based on observation with the Maintenance Manager on 10/13/15 at 11:18 a.m., then again at 12:06 p.m., the Resident smoking area had at least 25 cigarette butts on the ground. Then again the Staff smoking area had about 50	K 0066	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **What corrective actionswill be accomplished for those residents found to have been affected by the deficientpractice?** Cigarette butts werecleaned up both in the staff smoking area and the resident smoking area on10/14/15 and staff re-educated on smoking policy and proper	11/12/2015

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	cigarette butts on the ground. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned conditions. 3.1-19(b)		disposal of cigarettebutts in appropriate metal containers on 10/30/15. **Identification of otherresidents having the potential to be affected by the same alleged deficientpractice and corrective actions taken.** Reviewed otherpotential areas for cigarette butts and these areas had no findings. **What measures will beput into place or what systematic changes you will make to ensure deficientpractice does not recur?** Housekeeping staff willmonitor both staff and resident smoking areas for inappropriate discardedcigarette butts daily and will clean up immediately. Disciplinary action willresult for any employee not following the proper disposal of cigarette butts. **How will the correctiveaction be monitored to ensure the deficient practice will not recur?** Housekeeping staff willdaily monitor staff and resident smoking areas for inappropriate disposition ofcigarette butts. Housekeeping supervisor will report finding at the monthly QAPImeeting.	
K 0070 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such			

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	devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation, interview, and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect staff only. Findings include: Based on record review with the Maintenance Manager on 10/13/15 between 9:29 a.m. and 10:50 a.m., the space heater policy states the facility does not allow space heaters. Based on observation at 1:42 p.m., a space heater was discovered in the Director of Nursing office. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned condition and that space heaters were a violation of the facility's policy. 3.1-19(b)	K 0070	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **What corrective actionswill be accomplished for those residents found to have been affected by thedeficient practice?** The space heater locatedin the DON's office was removed immediately by the maintenance manager. Management Staff was in serviced on not usingspace heaters in the facility on 10/15/15. **How will you identifyother residents having the potential to be affected by the same deficientpractice and what corrective action will be taken?** All other offices infacility were inspected for space heaters an there were no findings. **Whatmeasures will be put into place or what systematic changes you will make to ensuredeficient practice does not recur?** Any further infractionsin the use of portable space heaters will result in disciplinary action. Housekeeping will monitor during office cleaningschedule to ensure	11/12/2015

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			no portable space heaters are being used. **How will the correctiveaction be monitored to ensure the deficient practice will not recur?** Housekeeping supervisorwill monitor office cleaning schedule and results will be reported to monthly QAPImeeting. This will be on-going.	
K 0075 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 3 of 3 areas with hazardous storage. This deficient practice could affect staff and up to 36 residents. Findings include: Based on observation with the Maintenance Manager on 10/13/15	K 0075	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. **Corrective actions accomplishedfor those residents found to be affected by the alleged deficient practice.** The 6 indicated 40gallon	11/12/2015

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	between 11:00 a.m. and 1:40 p.m., the following was discovered: a) One forty gallon container storing diapers in the corridor near resident room 407 b) One forty gallon container storing diapers in the corridor near resident room 405 c) Two separate forty gallon containers storing trash in the Large Dining Room d) Two separate forty gallon containers storing soiled linen and one forty gallon container storing trash in the corridor next to the 500 Hall nurse's station. Based on an interview at the time of each observation, the Maintenance Manager acknowledged each of the aforementioned conditions. 3.1-19(b)		containers were replaced with 32 gallon containers on 10/22/15. **Identification of otherresidents having the potential to be affected by the same alleged deficientpractice and corrective actions taken.** All residents had thepotential to be affected, however there was no actual harm to any. **Measures put in placeand systemic changes made to ensure the alleged deficient practice does notrecur** On 10 /22/2015 the Laundry/Housekeeping/NursingDepartments were re-educated on the use of the new 32 gallon containers. The housekeepingsupervisor or designee will inspect for compliance weekly. **How will the correctiveaction be monitored to ensure the deficient practice will not recur?** Resultsof weekly audits will be reported at QAPI monthly or until problem isconsidered resolved. Problem will be considered resolved when no newissues are identified over a two month period.	
K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 fire barrier walls was maintained to ensure the fire resistance of the barrier.	K 0130	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of	11/12/2015

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	LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect staff and 35 residents using the Large Dining Room.		this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law **Corrective actionsaccomplished for those residents found to be affected by the alleged deficient practice**. All penetrations noted will be sealed with 3M Fire Barrier 4Hr rated system by 11/12/15. 2. **Identification ofother residents having the potential to be affected by the same allegeddeficient practice and corrective actions taken.** All remaining smokebarriers were inspected for un-sealed penetrations. No findings. 3. **Measures put inplace and systemic changes made to ensure the alleged deficient practice doesnot recur.** Any new construction or repairs involving wires or pipes penetratingfirewalls will be sealed with 3M Fire Barrier 4Hr rated system. 4. **How will thecorrective action be monitored to ensure the deficient practice will not recur?** Any new construction orrepairs involving wires or pipes penetrating firewalls will be inspected by theMaintenance Manager, or designee, for appropriate fire barrier	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Findings include: Based on an observation with the Maintenance Manager on 10/13/15 at 2:14 p.m., the fire barrier wall near the Kitchen above the ceiling tile had an unsealed penetration measuring one inch around conduit, a four inch by 6 inch penetration about conduit, a five inch by five inch gap around wires, and a 14 inch by 8 inch brick was removed. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned conditions and provided the measurements. 3.1-19(b)		applicationprior to completion of project.	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 multiplugs and 7 of 7 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient	K 0147	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law **Corrective actionsaccomplished for those residents found to be affected**	11/12/2015

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	practice affects staff and up to 37 residents. Findings include: Based on observation with Maintenance Manager on 10/13/15 between 11:13 a.m. to 1:46 p.m. the following was discovered: a) a surge protector powering a refrigerator in the Dietary Office. b) a multiplug powering the time clock in 300 Hall c) an extension cord powering a refrigerator in the Activities Office. d) an extension cord powering a radio and microwave, additionally a surge protector was powering a microwave and refrigerator in the Maintenance Room. e) a surge protector powering a refrigerator in the 400 Hall Medication Room. f) an extension cord powering a copier in the Electrical Closet g) a multiplug powering two refrigerators in the 500 Hall Nurse's Station Medication Room. h) a surge protector powering a refrigerator in resident room 501 Based on interview at the time of observation, the Maintenance Manager acknowledged each aforementioned condition.		**by the alleged deficientpractice.** **1.)** All indicated extension cordsand surge protectors will be removed by 11/12/15. 2.) All indicated missing outlet covers wereinstalled on 10/16/15. **Measures put in placeand systemic changes made to ensure the alleged deficient practice does notrecur.** 1.Management staff was in-serviced on how extensioncords are not to be used in the facility. This was completed on 10/19/15. 2.A survey of the facility confirming that allelectrical outlets had covers. No other issues. **How will the correctiveaction be monitored to ensure the deficient practice will not reoccur?** The maintenancesupervisor or his designee will conduct weekly rounds to ensure that extensioncords are not being used for anything other than for temporary use. **How will the correctiveaction be monitored to ensure the deficient practice will not recur?** The results of this review will be presentedat the monthly QAPI meeting. Monitoring will be on-going.	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 53 resident rooms, 1 of 1 Therapy rooms, and 1 of 1 400 Halls . NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff and 25 residents. Findings include: Based on observations with the Maintenance Manager on 10/13/15 between 11:33 a.m. and 12:59 p.m., the following was discovered: a) a missing outlet cover behind the multiplug adapter for the time clock in the 300 Hall b) a missing outlet cover in East Wing Therapy c) a missing outlet cover in resident room 312 Based on interview at the time of each observation, the Maintenance Manager acknowledged each aforementioned condition. 3.1-19(b)			